Behavioral Science Activities in a VD Program

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IN DECEMBER 1961 a national task force recommended to the Surgeon General of the Public Health Service a series of behavioral science studies "to provide relevant insights" into human activities that result in venereal disease. There was an implicit assumption by the task force committee that the term "behavioral science" and the professional function of the discipline were known. They believed that the assigned objectives of those who were to develop research projects "into why these people [who contract venereal disease] are what they are . . . and that the implication of what they do" were obvious. And they thought that the need for information in the social, cultural, and psychological areas of the disease, in which there is "a critical lack of knowledge," was recognized (*1*).

However, when the Behavioral Science Activities program became an integral part of the Venereal Disease Branch of the Public Health Service on July 1, 1963, the questions first asked of the sociologist who was appointed to develop the program were: Who and what is a behavioral scientist? what does he do? how does he function? and what are his objectives?

The initial problem—and it is a continuing one—was to gain acceptance for a new discipline. The Behavioral Science Activities program was to be developed within a Federal agency whose responsibility is the medical control of an infectious disease. It was necessary, therefore, to communicate to the agency's professional staff and fieldworkers, and to associated agencies and personnel, the objectives of the new program and the significance of the research that had been proposed. They had to know if the section would be effective, if it could fulfill its responsibilities professionally, and if it could provide—as the task force had assumed it could—answers or at least guidelines to venereal disease control problems through a better understanding of the values, attitudes, and behavior of individuals and groups.

In stating what behavioral science activities are and should be in a national venereal disease program, those responsible for the development of the new section found that they could make no assumptions on what was known about the new discipline even among the most competent and intelligent of the staff. It was necessary to recognize that to a great many people the behavioral scientist is a new breed of professional, variously identified, and often only vaguely understood.

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The Behavioral Scientist

The term "behavioral science" gained recognition in the early 1950's. Berelson (*2*) writes that it came into widespread use when the Ford Foundation initiated and supported with several millions of dollars a behavioral science program. The person called a behavioral scientist carries a professional title that, at this writing, has no academic source. However, the designation identifies a person who has received

research training and who is aware of and uses various methodological procedures to obtain data that are factual, reliable, and verifiable. The behavioral scientist is concerned primarily with human behavior and group relationships. He provides findings that can be applied and are of program or public importance.

The similarities and differences in the role and function of the behavioral scientist and those of the social scientist have caused confusion. There is a natural tendency to use the terms interchangeably; although individuals may identify themselves as either or both, important differences exist. Social scientists are professionally trained in one of six disciplines: history, political science, economics, sociology, psychology, and anthropology. They may be academicians; they may be researchers; they may operate outside of an educational institution. However, in large part, their principal identification is an academic one.

In contrast, behavioral scientists function outside of a university setting, and their activities are more restricted in scope. They usually include scientists in only three professional areas—sociology, social psychology, and cultural anthropology—who serve as applied researchers in a specific agency or for a particular type of program. They frequently act as administrative scientists with responsibilities in a defined area or for a designated objective. Their research direction and study findings are incorporated into a program for or applied to a variety of human needs.

The behavioral scientist examines the usual, the available, the normal day-to-day occurrences, without preconceived notions. He seeks, and may discover, information that confirms or confronts or contradicts what is preached, what is believed, and what is practiced. He may ask, "Is it really so?" (*3*) as more than a question. The behavioral scientist's query may become a hypothesis, the basis for a scientific evaluation of accepted myths and procedural folkways.

His findings can be disturbing. He may look at what his study has revealed and say, "You were all wrong; here are the facts." Therefore, the behavioral scientist's data must be reliable, his methods objective, and his professional orientation dispassionate. As a human being, it is not always possible for the behavioral scientist to look at all things, at himself, or at other human beings, without certain biases. But it is only by his detachment and the rational examination of the acts and activities of others and of existing conditions that the social scientist or the behavioral scientist may be able to make his contribution to a program.

There are natural, perhaps inevitable, reactions to the behavioral scientist and his methods, his observations, and his findings. Scientific truthseekers are, at times, as annoying as gadflys. Their findings, however, cannot be shunted aside as academic artifices nor can they be dismissed as the ideological woolgatherings of fuzzy philosophers. Unfortunately, social phenomena are not physical facts, and people who are touched by what is said of them as people—react. A man who aspires to much and finds himself checkmated by a sociological category is disturbed by the classification into which he is placed, and by the classifier. Perhaps Keller (*4*) best described the difference between the physical and the social scientist when he said: "A man can count the legs of a fly and report his findings without having his heart wrung because there are too many or too few."

Preparation for VD Behavioral Studies

People differ, and their differences can be grouped. Sociomedical studies have shown that although the vaccines used today are safe and effective against poliomyelitis, a considerable number of people fail to accept immunization (*5*). Who are they? How do they differ from those who accept preventive medical treatment? We know that illness and disease are perceived differently by different cultural or subcultural groupings (*6*, *7*). The patient-physician relationship varies according to the group identity of each, the cultural backgrounds of the interacting parties, and the subcultural patterns used in interpreting each other's roles and in establishing rapport (*8*). Why are there differences? Among whom are there differences? How do differences affect treatment?

There is often a "push me-pull me" conflict within the social structure of an institution. Those who function in certain patterned relationships within a bureaucratic setting may operate at cross purposes or may circumscribe

program needs for self-aggrandizing purposes, or the organization may have a dual system of values and behavior. There frequently are divisive lines of authority as well as a disparity in goals; there may be a failure to recognize primacy; there may be an avoidance of change or a disinclination to evaluate effectiveness (*9–11*). How do the internal operations of an institution affect patient care?

The public health worker and the people he wishes to reach may not be able to communicate at the same level, and even knowledge and understanding of certain descriptive terms, as well as each person's perception of his public responsibilities as differentiated from his individual rights, may be interpreted or reinterpreted in terms of professional background, vested interests, or the values and behavior of a particular group (*12–15*). Interpersonal relations and the exchange of information may be blocked by words as well as by meanings. A statement by Kinsey and co-workers (*16*) points up the obvious: "Vocabularies," they said, "differ in different parts of the United States, and there are differences among individuals belonging to different generations." For example, "Sexual vocabularies may differ among persons in . . . a city, depending upon their social levels, occupational backgrounds, racial origins, religious and educational background, and still other factors."

The health worker must understand why some people are opposed to fluoridation and know who they are (*17*, *18*). He must recognize the importance of attitudes toward drinking and the result of such attitudes in terms of alcoholism (*19–22*). He must ascertain the impact of education, prevention, and treatment on venereal disease and know who can be reached by a particular type of program and what is needed to reach those who have erected a cultural barrier.

Relevance of Activities to VD Program

With sociocultural and psychological data derived from studies in other health-illness problem areas, the behavioral scientist who enters a venereal disease program develops his research frame of reference and applies the principles of his profession to the particular needs of the organization. He knows that the objectives of the section are to identify, evaluate, and provide meaningful findings that may be used to correct situations which hinder a program for the control of venereal disease.

The achievements of behavioral scientists in other medical areas are only idealistic concepts unless they can be duplicated in the new program that the sociologist enters. But a danger exists. The behavioral scientist may seek the easy way. Researchers have attempted to transfer reliable methods and to use tested techniques that have been of value in other reported studies to every research project that they enter. Their training, professional narrowness, lack of creativeness, or personal inertia may cause them to reach out for the familiar or the accessible and to use a microcosmic approach. It must be recognized that every research project is a new problem in methodological approach, procedures, and analysis. Research in other areas can be used only as guidelines in a program that may have specific needs and different objectives.

The Behavioral Science Program in VD

Research is the program's principal concern, but the word "research" covers too much and can mean too many things. Because behavioral science research needs specialized techniques for each project, and the area of study is some type of human behavior, the investigator faces two immediate problems. The first is what to select. Priorities have to be set, and peripheral interests must not divert the researcher from program needs. Administrative recognition is needed that an evaluation of an accepted practice may be more important than an investigation of "something new."

Second, professional criteria are necessary for every research project. Thus a study that requires too much time or covers too many variables may be rejected by the researcher because he is cognizant that a small reliable study with results that may have immediate application is more important than a study which continues indefinitely and becomes "research for the sake of research" rather than for a program need.

Although national studies for syphilis and

gonorrhea are needed, it may be advisable at the beginning to conduct pilot projects that can be replicated regionally and subjected to a broader test. Small, reliable, and verifiable studies that are limited to a local need or probing research expeditions may be of great value.

The venereal disease program has a responsibility for contractual studies. These fall into two categories: studies that the behavioral science section of the Venereal Disease Branch designs and places with a competent group of specialized personnel, who will conduct the project according to the outline prepared in the branch office; second, study proposals submitted by outside agencies for support, which the staff reviews in terms of program objectives and technical competence. The value of submitted proposals cannot be overemphasized. The projects may be in a research area that was overlooked by the venereal disease staff until the suggestion was received or may contain a new technique or approach to a venereal disease problem.

Contractual studies are supervised by the behavioral science staff to assure that they conform to the objectives for which funds were granted and to review periodically the methodological procedures that are used. The Behavioral Science Activities section has established the following guidelines for "farmed out" research projects.

- Contractual arrangements must be clear, not only in terms of budget and time needed to conduct a proposed study but also in delineating the scope of the project (the study area), the staff needed, and the technical tools and methodological procedures to be used. These have to be specified and understood by both contracting parties.
- The study area and technical aspects (the methodology) include two related considerations: Is the project valid in terms of agency need, and will it furnish information of value to a venereal disease program? Are the techniques to be used methodologically sound and are the procedures and research considerations realistic and scientifically justified?
- The contractor must be cognizant of the progress of the project, and liaison—as a euphemism for review—must be maintained during the entire period of the study.
- Does the project when completed fulfill the objective for which funds were allotted, and how can the data be utilized?

In interdisciplinary research, the behavioral scientist sits down with physicians, statisticians, laboratory technicians, and others and plans a cooperative study. The behavioral scientist in an interdisciplinary project is part of the research team for the entire study period, from the planning stage through each subsequent procedural step.

The research area of the venereal disease behavioral science activities program can be:

1. National or regional studies planned, developed, and directed by a staff from the central office.
2. Pilot studies, usually small and easily controlled, that may be undertaken by the staff or placed with an outside study group under the direction of the behavioral science staff.
3. Interdisciplinary studies that are developed with other members of the venereal disease staff or are cooperative research ventures with university groups or State health departments.
4. Contractual studies in which the behavioral science staff will review the project design and methodological procedures of research that is conducted independently by an outside group.

Another important area which the behavioral science staff is prepared to enter is consultation. For example, the staff members can be asked by statisticians to review a form, by epidemiologists to suggest new methods for contact interviewing, and by administrators to suggest better lines of communication within an organization.

The staff also is available to provide related consultative services to universities and medical schools, to research groups and other professionals and agencies, to field staffs, and to health departments.

The projected areas of professional function of a behavioral science activities program are dependent on the staff that can be obtained. A new program must attract and, to some extent, retain a staff if its objectives are to become a reality. The staff needs will be based upon those aspects of the broad spectrum that can be covered.

We recognize that our program may have to operate with a limited staff for some time and that it cannot become directly involved in

many types of studies that, however fruitful they may be, are tangential to the immediate program needs of the Venereal Disease Branch. Therefore, we have proposed a plan for the assignment of graduate students for short periods of training, and for the support of graduate theses and dissertations. In this manner we think the program will benefit by studies conducted in areas in which the behavioral science section cannot work directly. It also is anticipated that graduate students in sociology, social psychology, and cultural anthropology will become interested in the career possibilities open to them in a public health field.

Summary

In December 1961 a task force report on syphilis control in the United States was forwarded to the Surgeon General of the Public Health Service. Among the report's major recommendations was the need for extensive behavioral science studies. On July 1, 1963, a behavioral science activities program was initiated and a sociologist was appointed chief of the new headquarters unit in the Venereal Disease Branch of the Public Health Service's Communicable Disease Center in Atlanta.

Behavioral science is a relatively new discipline in many agencies, and a number of questions were raised about the role and function of the behavioral scientist as a professional and, specifically, his position and responsibilities in a venereal disease program.

The behavioral scientist has been described as a researcher who, with new approaches, examines human behavior as social or group phenomena. His studies are conducted in terms of agency need and should provide factual data for administrative action. The perspective and research methods of the behavioral scientist require a detached scientific approach. Since he investigates sensitive social problem areas, the sociologist must be careful to use reliable and verifiable methods in his research projects.

To develop the operational frames of reference for a new agency, the behavioral scientist reviews studies in related sociomedical fields and notes that group differences have been reported as important in expressed attitudes held and in behavior patterns manifested toward illness and health and toward treatment and the physician. The need of the public health worker to know and recognize the different group attitudes of patients and the need of the public health worker to be cognizant of his own values and how they affect his relationship with the patient were emphasized.

The potential areas of behavioral science research are national and regional studies, pilot projects, interdisciplinary studies, research consultative services, and reviewing contractural projects.

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Administration of Medicare Insurance

The Social Security Administration, the Welfare Administration, and the Public Health Service are responsible for the administration of the new and expanded programs of the health insurance and medical care provisions of the new social security amendments.

It is the goal of these agencies to see that the American people receive full benefits of this new legislation within the established framework of health and medical care practice in this country. Appropriate health agencies and organizations will be consulted in order to promote effective cooperation among all interested groups.

General management and operation of the hospital insurance program and the supplemental medical insurance program will be provided by the Social Security Administration. An important aspect of this agency's responsibility will be to develop appropriate arrangements with other administrative agents that will be involved in the operation of both programs.

The Welfare Administration will be responsible for the development and administration of health and medical care standards for State programs for needy and near-needy persons and families as well as for the administration of project grants for comprehensive health programs for school and preschool children.

Under the new legislation, the Social Security Administration and the Welfare Administration will work closely with the Public Health Service, which will have principal responsibility for the professional aspects of the hospital and medical insurance programs, including the promulgation of higher standards of care provided by hospitals, nursing homes, and home health agencies.

The Public Health Service has established a Division of Medical Care Administration in the Bureau of State Services. This Division will carry out the Service's additional responsibilities under the new legislation as well as administering the medical care activities previously handled in other units of the bureau. Dr. John W. Cashman, formerly deputy chief of the Division of Community Health Services, heads the new division.